JEFFREY MATSON DDS

Your Dental Home

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms.

PATIENT INFORMATION

Name: _____ Date of birth: _____ Sex: ____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

SSN: _____ Employer/Occupation: _____

Previous Dentist: _____ Last dental visit: _____

Emergency contact: _____ Phone: _____
(Please include relation)

Referred By: _____

INSURANCE

Primary Dental Insurance

Name of Subscriber: _____ Date of Birth: _____

Dental Insurance Company: _____ ID#: _____
(Use subscriber's SSN if member ID# not available)

Insurance Mail/Claims Address: _____

Insurance Phone Number: _____

Secondary Dental Insurance

Name of Subscriber: _____ Date of Birth: _____

Dental Insurance Company: _____ ID#: _____
(Use subscriber's SSN if member ID# not available)

Insurance Mail/Claims Address: _____

Insurance Phone Number: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing?	☐	☐
Do you chew on one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐
Does your jaw make noises?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaws get stuck that you can't open freely?	☐	☐
Does it hurt when you chew or open wide?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms of headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (Pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have temporomandibular disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, throat, or temple?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

How often do you brush? _____

How often do you floss? _____

HEALTH HISTORY

Does your doctor require you to take an antibiotic prior to dental treatment? Yes No

Heart Problems	Y	N
Chest pain	☐	☐
Shortness of breath	☐	☐
High/low BP (circle one)	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Artificial heart valve	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐

Blood Problems		
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
High cholesterol	☐	☐
Require blood transfusion?	☐	☐

Allergy Problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Asthma	☐	☐

Bone/Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Artificial joint (hip/knee)	☐	☐
Osteoporosis	☐	☐

Intestinal Problems		
Ulcers	☐	☐
Acid reflux	☐	☐
Weight gain or loss	☐	☐
Special Diet	☐	☐
Constipation/diarrhea	☐	☐
Kidney/bladder problems	☐	☐

Diabetes		
Urinate 6 times or more a day	☐	☐
Thirsy or dry mouth	☐	☐
Family history of diabetes	☐	☐

Other Problems		
Fainting, seizures, epilepsy	☐	☐
Stroke	☐	☐
Frquent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough	☐	☐
Swollen glands	☐	☐
TB or other respiratory disease	☐	☐
Hepatitis, jaundice, or liver issues	☐	☐
Herpes or other STD	☐	☐
HIV positive/AIDS	☐	☐
Glaucoma	☐	☐
History of head injury	☐	☐
Cancer (history of tumor)	☐	☐
Chemo/radiation treatment	☐	☐
If yes, when _____		
Do you smoke?	☐	☐
If yes, since when _____ Frequency _____		
Do you use chewing tobacco?	☐	☐
If yes, since when _____ Frequency _____		
History of alcohol/drug abuse?	☐	☐
If yes, when _____		
Are there other conditions we should know about?	☐	☐
Please describe: _____		
_____		

Are you allergic or reacted adversely to:		
Local anesthetics	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates/sedatives/etc	☐	☐
Aspirin, Acetaminophen, Ibuprofen	☐	☐
Codein, Demerol, other narcotics	☐	☐
Metals	☐	☐
Latex or rubber dam		
Other _____		

Please list (or attach) **ALL** medications:

_____

_____

_____

Date:
BP:
Pulse:

_____ _____
Patient/Parent Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This notice takes effect **04/14/2003** and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, & healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to receive and/or review a copy of Jeffrey Matson DDS' Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

Printed Patient Name

Printed Name/Relationship if Signed by Individual Other than Patient

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but could not because:

- ☐ Individual refused to sign
- ☐ Communication barrier
- ☐ Care provided was emergent
- ☐ Other:

_____

_____ _____

Employee Name Date

BUSINESS POLICIES

APPOINTMENTS: When we schedule an appointment for you, we reserve a block of time in a private treatment room, investigate your insurance benefits, prepare your chart records, and assign a clinical staff person to be with you for the duration of the appointment.

In a similar spirit of anticipation, we ask that you make every attempt to keep your scheduled appointment.

CANCELLATION/NO SHOW: We understand that "life" happens and there are times you must miss an appointment due to emergencies or obligations for work or family. However, we **require at least a 24 hour notice if you need to cancel your appointment.** If failed to do so, a same day cancellation/no show fee will be charged. If a pattern of failed appointments develops, we may request that you seek dental care in another practice that could better accommodate your schedule.

DENTAL INSURANCE: As a courtesy to you, we maintain technology and staff to bill most dental insurance companies. Once you have provided us with the necessary information (see Required Information to Bill Dental Insurance form), we will send claims to your dental insurance company.

Please be aware that we make every attempt to collect information from your dental insurance company in terms of how your benefits work and what you can expect to pay for out of pocket. But, we *offer no guarantees* about how your dental insurance will actually pay once claims are processed. Ultimately, you are responsible for any portion of treatment that insurance does not pay for. Dental insurance is a specific contract between you, your employer, and the insurance company. We encourage you to become familiar with your plan's maximums, deductibles, waiting periods, and exclusions. Typically, you can gather information from the insurance website and/or your employer's Human Resource Department.

PAYMENT: We ask that you pay any deductibles and estimated patient portions at the time of service (unless you have made payment arrangements with the practice manager).

LATE FEE: You will be charged a late fee for balances older than 90 days.

I have read all of the above, and I understand Dr. Jeffrey Matson's business policies.

_____ _____

Signature of patient (or legal guardian) Date